NATIONAL HEALTH COUNCIL

March 13, 2026

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program [CMS-9883-P]

Submitted electronically via regulations.gov

Dear Administrator Oz:

The National Health Council (NHC) appreciates the opportunity to submit comments in response to the proposed 2027 Notice of Benefit and Payment Parameters (NBPP).

Created by and for patient organizations more than 100 years ago, the NHC convenes organizations from across the health ecosystem to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, comprehensive, accessible, and sustainable health care. Made up of nearly 200 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

The NHC has consistently supported Marketplace policies that promote affordability, stability, meaningful consumer choice, and comprehensive coverage for individuals living with chronic conditions and disabilities. The 2027 NBPP proposes significant changes affecting eligibility verification standards, Exchange program integrity, plan design flexibility, issuer oversight, and market integrity mechanisms. The cumulative effect of these changes warrants careful evaluation to ensure that efforts to strengthen program integrity and operational safeguards do not inadvertently introduce additional barriers to enrollment, reduce benefit adequacy, or increase financial risk for those who rely on Marketplace coverage as a primary source of insurance.

The NHC recommends that the Centers for Medicare & Medicaid Services (CMS):

- Implement eligibility and verification requirements in a targeted and data-driven manner that minimizes coverage delays, enrollment disruption and avoidable coverage loss;

- Maintain robust consumer transparency standards, disclosure requirements, and decision-support tools, particularly considering proposed changes to standardized plan offerings and other sources of plan design complexity;
- Preserve strong network adequacy, Essential Community Provider, and related access standards to safeguard timely access to specialty, sub-specialty, and safety-net care;
- Carefully evaluate the impact of expanded plan design flexibility, proposed catastrophic plan changes, and related cost-sharing policies on out-of-pocket exposure, underinsurance, and the practical value of coverage;
- Implement Essential Health Benefits-related and other benefit design policies in a manner that preserves meaningful access to medically necessary services and does not inadvertently discourage coverage improvements; and
- Assess the cumulative impact of the proposed policies on coverage stability, benefit adequacy, and financial protection for individuals managing chronic and complex health conditions.

The NHC provides the following comments on specific provisions of the proposed rule and highlights several areas where implementation will be particularly important for individuals and families who rely on Marketplace coverage, including family caregivers who frequently manage enrollment processes, documentation requirements, and continuity-of-care needs on behalf of children, older adults, and individuals with disabilities.

CMS Enforcement in the Individual and Group Markets (Part 150)

CMS proposes to amend § 150.317 to clarify that the Department of Health and Human Services (HHS), through CMS, will identify the lawful purpose or purposes of a civil money penalty (CMP) and consider enumerated factors, as appropriate, when determining the amount of a penalty.

Transparency regarding the factors that inform enforcement actions and related remedies may promote predictability in regulatory expectations and support compliance planning. Enforcement clarity is particularly important in the Marketplace context, where actions affecting qualified health plan issuers can have downstream implications for enrollees, including effects on plan participation, network arrangements, and continuity of coverage. As CMS finalizes this amendment, continued attention to minimizing unintended disruption to consumers receiving ongoing care will be important, including through enrollee protection and transition safeguards where enforcement actions affect issuer participation or plan operations. This is particularly important where patients and caregivers are coordinating ongoing treatment, prior authorizations, and provider transitions.

Risk Adjustment and Market Stabilization (Part 153)

The NHC supports the continued administration of the permanent risk adjustment program established under section 1343 of the Affordable Care Act (ACA). The NHC also appreciates CMS' confirmation that it will operate risk adjustment in every state and the District of Columbia for the 2027 benefit year, as no states requested to operate

their own risk adjustment program. A consistent, well-calibrated risk adjustment program remains essential to mitigating incentives for risk selection and to sustaining stable issuer participation in the individual and small group markets, including for plans that enroll individuals with high-cost and complex conditions.

HHS Risk Adjustment Model Recalibration for the 2027 Benefit Year (§ 153.320)

CMS proposes to recalibrate the 2027 benefit year HHS risk adjustment models using enrollee-level External Data Gathering Environment (EDGE) data from the 2021, 2022, and 2023 benefit years, including continued use of blended coefficients across three years of separately solved models. A multi-year approach may promote year-to-year stability and smooth volatility in model outputs, which can assist issuers in pricing and planning decisions. Model stability is particularly relevant for individuals with chronic and complex conditions, whose access to coverage depends in part on predictable risk adjustment transfers that support stable participation by issuers.[1]

The NHC encourages continued transparency regarding model performance and the degree to which the recalibrated models predict plan liability for populations with complex needs, including individuals managing multiple chronic conditions. CMS' discussion of model performance statistics, including R-squared values and predictive ratios, supports stakeholder assessment of whether model updates maintain appropriate predictive performance across relevant enrollee populations.

The NHC also notes CMS' statement that draft coefficients may change between the proposed and final rule if errors are identified or if the proposed models are modified in response to comments, and that final coefficients may be published in guidance if necessary. Given the central role of these coefficients in issuer pricing and plan design decisions, the NHC encourages CMS to provide as much lead time as practicable and to maintain predictable timing for the release of final coefficients or related guidance.

Comment Solicitation on Separate Risk Adjustment Transfer Calculations for Catastrophic and Non-Catastrophic Plans

CMS solicits comment on whether to retain separate risk adjustment transfer calculations for individual catastrophic plans and individual non-catastrophic plans or to calculate transfers together. CMS frames this solicitation in light of September 4, 2025 guidance expanding eligibility for hardship exemptions that may allow additional consumers to enroll in catastrophic plans beginning with plan year 2026.[2] The NHC appreciates CMS' solicitation and encourages evaluation of this issue through the lens of risk pool stability, premium impacts, and consumer financial protection. If catastrophic

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[1] Jeanne M. Lambrew and Christen Linke Young, *Lessons from the ACA: Simplifying Choices to Optimize Health Coverage* (Commonwealth Fund, December 2, 2025), https://www.commonwealthfund.org/publications/issue-briefs/2025/dec/lessons-aca-simplifying-choices-optimize-health-coverage.

[2] Centers for Medicare & Medicaid Services, *Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-Sharing Reductions Due to Income* (Baltimore: CMS, September 4, 2025), https://www.cms.gov/files/document/guidance-hardship-exemptions.pdf.

plan enrollment increases in a manner that materially alters the composition of catastrophic and non-catastrophic risk pools, it could affect transfer payments, premiums, and issuer participation.[3,4]

The NHC recommends that CMS assess and publicly describe how maintaining separate calculations, versus combining calculations, could affect: 1) the composition of catastrophic and non-catastrophic risk pools, 2) premium levels in each segment, and 3) transfer outcomes under the state payment transfer formula. CMS' analysis would also benefit from considering whether any change could influence plan design or enrollment patterns in ways that increase underinsurance or increase consumer cost exposure, particularly through higher deductibles and other cost-sharing structures that are characteristic of catastrophic coverage.[5]

HHS-RADV Error Estimation Modification Beginning with 2025 Benefit Year HHS-RADV (§§ 153.350 and 153.630)

HHS-Risk Adjustment Data Validation (RADV) functions as a program integrity mechanism intended to promote accurate data submission and ensure that risk adjustment transfers reflect verifiable actuarial risk differences.[6] CMS proposes to add an additional scaling factor, α_i, beginning with the 2025 benefit year HHS-RADV, to estimate the proportion of an issuer's total plan liability risk score associated with enrollees with HCCs using EDGE data. CMS indicates that the proposed scaling factor is intended to preserve application of HCC-associated error rates while avoiding unintended adjustments to portions of risk scores attributable to enrollees without HCCs. Because risk adjustment transfers influence issuer pricing and market participation decisions, predictable implementation of HHS-RADV methodologies remains important for market stability. CMS should provide clear operational guidance regarding application of the proposed scaling factor will help reduce avoidable uncertainty affecting premium development and issuer participation.[7,8]

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[3] Karen Pollitz, Justin Lo, and Rayna Wallace, "Standardized Plans in the Health Care Marketplace: Changing Requirements," KFF, May 8, 2023, https://www.kff.org/private-insurance/standardized-plans-in-the-health-care-marketplace-changing-requirements/.

[4] JoAnn Volk, Sabrina Corlette, and Justin Giovannelli, "New Guidance Expands Pool of Individuals Eligible to Purchase Catastrophic Plans," *State Health & Value Strategies*, September 5, 2025, https://shvs.org/new-guidance-expands-pool-of-individuals-eligible-to-purchase-catastrophic-plans/.

[5] Zarek Brot-Goldberg et al., "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics," *Quarterly Journal of Economics* 132, no. 3 (2017): 1261–1318, https://doi.org/10.1093/qje/qjx013.

[6] Ashley Feher and Isaac Menashe, "Using Email and Letters to Reduce Choice Errors among Low-Income Marketplace Consumers," *Health Affairs* 40, no. 5 (May 2021): 720–728, https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.02099.

[7] Centers for Medicare & Medicaid Services, *Benefit Year 2023 HHS-RADV Adjustments to Risk Adjustment Transfers Report* (Baltimore: CMS, July 21, 2025).

HHS-RADV also requires submission of demographic, enrollment, and medical record documentation and engagement of independent validation entities. Documentation and audit expectations should remain aligned with data integrity objectives to ensure that program oversight is maintained without introducing unnecessary operational complexity that could increase administrative costs and ultimately be reflected in premiums without commensurate program integrity benefit.

HHS Risk Adjustment User Fee for the 2027 Benefit Year (§ 153.610(f))

CMS proposes setting the HHS risk adjustment user fee at $0.20 per member per month (PMPM) for the 2027 benefit year and provides an explanation of projected administrative expenses and billable member months. Because user fee rates are incorporated into issuer premium calculations, transparency regarding cost projections and enrollment assumptions is important. Clear articulation of how CMS evaluates projected operating costs and enrollment estimates will assist stakeholders in understanding how user fee collections relate to operational needs. As CMS finalizes the rate, continued communication regarding updated enrollment projections or cost assumptions would help reduce uncertainty for issuers and Exchanges planning for the 2027 benefit year.

Rate Review and Premium Transparency (Part 154)

The NHC appreciates CMS' focus on improving transparency and oversight regarding plan-level premium adjustments intended to account for unreimbursed cost-sharing reductions (CSRs).[9] CSRs are a central affordability protection for Marketplace enrollees with incomes between 100 and 250 percent of the Federal Poverty Level who enroll in silver QHPs, as well as eligible American Indian and Alaska Native enrollees. In the absence of federal reimbursement, issuers and State regulators have adopted a range of approaches to account for CSR costs through premium "loading," most commonly by applying adjustments to silver plan premiums.[10] As CMS notes, these approaches vary substantially across states and issuers and, in some cases, may produce premium impacts that differ from projected unreimbursed CSR obligations. The NHC recognizes that variation in CSR loading approaches, and CSR load factors that are not closely aligned with projected unreimbursed CSR obligations in either direction, including due to forecasting uncertainty and enrollment distribution assumptions, may

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[8] Elena Faugno et al., "'Pick a Plan and Roll the Dice': A Qualitative Study of Consumer Experiences Selecting a Health Plan in the Non-Group Market," *Health Policy Open* 5 (December 2023): 100112, https://doi.org/10.1016/j.hpopen.2023.100112.

[9] Emma Wager and Cynthia Cox, *Explaining Cost-Sharing Reductions and Silver Loading in ACA Marketplaces* (San Francisco: KFF, June 26, 2025), https://www.kff.org/uninsured/explaining-cost-sharing-reductions-and-silver-loading-in-aca-marketplaces/.

[10] Congressional Research Service, *Financing Cost-Sharing Reduction Reimbursements to Private Health Plans*, CRS Insight IN12562 (Washington, DC: Congressional Research Service, July 25, 2025), https://www.congress.gov/crs_external_products/IN/PDF/IN12562/IN12562.3.pdf.

influence relative pricing across metal levels and affect consumer plan selection. Ensuring that CSR load factors reflect reasonable assumptions can help support clearer pricing signals for consumers and maintain transparency in Marketplace premium structures.[11]

The NHC supports CMS' proposal to require issuers that make plan-level adjustments to account for unreimbursed CSRs to submit standardized information in the Unified Rate Review Template (URRT) and actuarial memorandum beginning with plan year 2027 rate filings.[12] The proposed data elements—including the amount of CSRs previously provided using the most recent annual data available, the additional revenue collected from the previously applied CSR load, the CSR load factor for the upcoming plan year and its underlying methodology, and a comparison of projected additional revenue to expected CSR payments—would strengthen rate review oversight. These data would also promote more consistent evaluation of whether CSR load factors are actuarially justified under § 156.80(d). The NHC also recognizes that leveraging the existing URRT submission process to collect aggregate plan-level information may represent a more administratively efficient approach than reinstating policy-level CSR data submissions through the CSR reconciliation process, while still providing regulators with meaningful insight into CSR pricing assumptions.[13]

The NHC encourages CMS to implement these reporting requirements in a manner that advances consumer affordability and market stability. Enhanced transparency will be most effective if accompanied by clear expectations regarding how CMS and state regulators will evaluate whether CSR load factors are calibrated to recover projected unreimbursed CSR obligations without materially exceeding those amounts.[14] The NHC recommends reinforcing this principle in the Unified Rate Review Instructions and related guidance. Clarification in the Unified Rate Review Instructions regarding reasonable methodologies and review factors would support consistent evaluation of assumptions related to enrollment distribution and utilization while maintaining a standardized and administratively feasible framework across states.

The NHC also encourages CMS to consider how strengthened rate review data can support consumer-facing transparency. CSR loading has become a structural feature of Marketplace pricing in many states, and the resulting premium differentials between

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[11] Christen Linke Young, "Understanding Marketplace 'Silver Loading,'" *Brookings Institution*, May 9, 2025, https://www.brookings.edu/articles/understanding-marketplace-silver-loading/.

[12] Kevin Dyke, *Cost Sharing Reduction (CSR) Referral to the Health Actuarial (B) Task Force Made at the 2023 Summer National Meeting*, memorandum to Anita G. Fox, June 3, 2024, National Association of Insurance Commissioners, https://content.naic.org/sites/default/files/call_materials/HATF%20CSR%20Memo%20B%20Committee_Final_20240603.docx.

[13] Matthew Fiedler, "The Case for Replacing 'Silver Loading,'" *Brookings Institution*, May 20, 2021, https://www.brookings.edu/articles/the-case-for-replacing-silver-loading/.

[14] Congressional Research Service, *Financing Cost-Sharing Reduction Reimbursements to Private Health Plans*.

metal levels may not be readily understood by consumers.[15] As CMS enhances oversight of CSR-related premium adjustments, additional efforts to communicate, in plain language, how CSR loading affects premiums and premium tax credit amounts could improve consumer comprehension and plan selection.

Exchange Eligibility, Enrollment, and Program Integrity (Part 155)

Eligibility Determinations and APTC Policies (§§ 155.20, 155.305, 155.320)

The NHC recognizes CMS' ongoing efforts to strengthen program integrity within the Exchanges, including proposed refinements to advance payments of the premium tax credit (APTC) eligibility determinations and income verification processes. Accurate eligibility determinations are essential to maintaining Marketplace stability and safeguarding federal expenditures. At the same time, integrity measures benefit from careful calibration to avoid erroneous terminations, preventable coverage gaps, or documentation burdens that may operate in practice as barriers to enrollment or continuity of care for eligible individuals.

CMS' proposal to limit APTC eligibility to individuals who meet the regulatory definition of "eligible noncitizens," along with related clarifications affecting individuals who are ineligible for Medicaid due to immigration status and whose incomes fall below 100 percent of the FPL, warrants careful evaluation. Individuals navigating immigration-related eligibility rules frequently encounter documentation complexity and verification delays that are outside of their control. If these changes are finalized, the NHC urges CMS to incorporate operational guardrails that reduce the risk of coverage loss resulting from data mismatches, processing delays, or system limitations. Clear and timely notices in plain language, reasonable response timeframes, and defined escalation pathways for consumers and assisters would support error resolution before coverage or APTC is discontinued. Ongoing monitoring and public reporting of implementation indicators—such as reinstatement rates following termination, coverage gaps attributable to verification, and dispute resolution timelines—would further strengthen transparency and accountability.

The NHC also encourages CMS to implement refinements to income verification procedures in a manner that minimizes avoidable enrollment disruption, particularly in circumstances where tax data are unavailable or where data sources indicate income below 100 percent FPL. Individuals with chronic conditions often experience income volatility due to episodic work capacity, disability status, or caregiving obligations, and rigid documentation standards may disproportionately affect these populations.[16] Caregivers may face similar volatility due to reduced work hours, episodic leave, or

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[15] Wager and Cox, *Explaining Cost-Sharing Reductions and Silver Loading in ACA Marketplaces*.

[16] Nora Becker et al., "Association of Chronic Disease With Patient Financial Outcomes Among Commercially Insured Adults," *JAMA Internal Medicine* 182, no. 10 (2022): 1045, https://doi.org/10.1001/jamainternmed.2022.3687.

fluctuating household composition that complicates documentation.[17] Where electronic data sources are unavailable, inconsistent, or inconclusive, maintaining flexibility for self-attestation where appropriate, coupled with post-enrollment verification may reduce delays in coverage activation. Time-limited verification processes, along with clear explanations of the basis for determinations and practicable submission pathways, would help reduce duplicative documentation requests and administrative churn.[18]

To the extent new or modified information collection requirements are implemented under the Paperwork Reduction Act, the NHC encourages CMS to provide detailed operational guidance to Exchanges and assisters to promote consistent application across enrollment channels. Predictable documentation pathways and clear standards for acceptable alternative verification where tax data are unavailable or untimely would help distinguish genuine ineligibility from data timing or reconciliation issues and reduce avoidable enrollment delays.

Failure to File and Reconcile Requirements (§ 155.305)

The NHC supports policies that promote compliance with the statutory requirement that individuals receiving advance payments of the APTC file and reconcile their federal income tax returns. Reconciliation plays an important role in maintaining program integrity and protecting federal expenditures. At the same time, enforcement approaches benefit from consideration of the practical barriers faced by low-income households, individuals with disabilities, and those experiencing housing instability or limited access to tax preparation assistance.

If revisions to failure-to-file enforcement or associated eligibility consequences are finalized, the NHC recommends incorporating graduated and consumer-centered safeguards prior to termination of APTC or coverage. Advance notices in plain language, clear identification of the specific tax year at issue, reasonable timeframes for resolution, proactive outreach where feasible, and explicit instructions regarding reinstatement pathways once compliance is achieved would help mitigate avoidable coverage loss. Procedural noncompliance, rather than substantive ineligibility, can result in significant care disruption for individuals managing chronic or complex health conditions.

Where notice requirements, verification steps, or documentation handling are expanded in connection with failure-to-file determinations, structuring associated information collection processes to facilitate consumer resolution—rather than merely documenting noncompliance—would support program goals. Streamlined reinstatement mechanisms

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[17] AARP and National Alliance for Caregiving, *Caregiving in the United States 2025* (Washington, DC: AARP Public Policy Institute, 2025), https://www.aarp.org/pri/topics/ltss/family-caregiving/caregiving-in-the-us-2025/.

[18] MaryBeth Musumeci et al., *Reducing Medicaid Churn: Policies to Promote Stable Health Coverage and Access to Care* (Commonwealth Fund, June 11, 2025), https://www.commonwealthfund.org/publications/issue-briefs/2025/jun/reducing-medicaid-churn-policies-promote-stable-health-coverage.

and clear operational guidance for assisters may help reduce avoidable churn once tax filing obligations are satisfied.

Pre-Enrollment Verification of Special Enrollment Periods (§ 155.420(g))

The NHC recognizes CMS' continued efforts to strengthen pre-enrollment verification for certain Special Enrollment Periods (SEPs) in order to mitigate improper enrollment and support premium stability.[19,20] Effective verification of SEP eligibility contributes to sustained issuer participation and overall market confidence.[21] At the same time, pre-enrollment verification policies function most effectively when structured to avoid unintended delays in coverage activation for individuals experiencing legitimate qualifying life events.

Individuals qualifying for SEPs often do so following disruptive events such as loss of employer-sponsored coverage, changes in household composition, relocation, or other significant transitions.[22] For households providing care, these transitions may coincide with urgent medication needs, caregiver work and scheduling constraints, and the need to maintain access to established treating clinicians.[23] For individuals with ongoing or complex health care needs, even short delays in coverage activation may interrupt medication access, delay procedures, or disrupt provider continuity. If pre-enrollment SEP verification requirements are expanded or refined, incorporation of expedited processing standards and clearly defined timelines for determinations would help reduce care disruption.[24,25] Consideration of presumptive or provisional coverage mechanisms in appropriate circumstances may also support continuity of care while documentation is under review.

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[19] Centers for Medicare & Medicaid Services, *Pre-Enrollment Verification Overview* (Baltimore: Centers for Medicare & Medicaid Services, June 29, 2017), https://www.cms.gov/marketplace/technical-assistance-resources/pre-enrollment-verification-overview.pdf.

[20] Centers for Medicare & Medicaid Services, "CMS Takes Aim to Reduce Improper Enrollments and Promote More Affordable Health Insurance Marketplaces," press release, March 10, 2025, https://www.cms.gov/newsroom/press-releases/cms-takes-aim-reduce-improper-enrollments-and-promote-more-affordable-health-insurance-marketplaces.

[21] Kaye Pestaina et al., "Fraud in Marketplace Enrollment and Eligibility: Five Things to Know," *KFF*, June 30, 2025, https://www.kff.org/patient-consumer-protections/fraud-in-marketplace-enrollment-and-eligibility-five-things-to-know/.

[22] Centers for Medicare & Medicaid Services, "Special Enrollment Period (SEP)," *HealthCare.gov*, accessed March 3, 2026, https://www.healthcare.gov/glossary/special-enrollment-period/.

[23] AARP and National Alliance for Caregiving, *Caregiving in the United States 2025*.

[24] Centers for Medicare & Medicaid Services, *Pre-Enrollment Verification Overview*.

[25] Anna L. Goldman and Sarah H. Gordon, "Coverage Disruptions and Transitions Across the ACA's Medicaid/Marketplace Income Cutoff," *Journal of General Internal Medicine* 37, no. 14 (November 2022): 3570–3576, https://doi.org/10.1007/s11606-022-07437-0.

Because pre-enrollment SEP verification involves additional documentation handling, associated information collection requirements benefit from being narrowly tailored to validation of the qualifying event and designed to avoid duplicative or difficult-to-obtain materials.[26] Ongoing monitoring of operational impact—including processing timelines, denial rates later reversed, and coverage gap duration—would support assessment of whether integrity objectives are achieved without creating predictable barriers for eligible individuals.

To the extent related legislative proposals affecting pre-enrollment Marketplace processes are under consideration, evaluation through the lens of coverage continuity and patient access, particularly for individuals undergoing active treatment, remains important.

Hardship Exemptions (§ 155.605(d)(1))

The proposed expansion of hardship exemption eligibility reflects recognition that consumers may encounter extraordinary circumstances that impede their ability to enroll in or maintain coverage.[27] The NHC supports maintaining accessible and clearly defined hardship pathways for individuals experiencing serious medical conditions, natural disasters, economic instability, domestic disruption, or other substantial barriers beyond their control.

For hardship provisions to function as an effective safety valve, timely processing and proportionate documentation standards are critical. Individuals seeking hardship exemptions frequently do so in the context of acute or destabilizing circumstances. Documentation expectations that are overly rigid or difficult to satisfy may deter eligible consumers or delay relief in ways that exacerbate financial and health-related stress.

CMS could further reduce churn by pairing these clarifications with timeliness expectations and by allowing reasonable alternative documentation when standard documents are unavailable due to the hardship circumstance. Monitoring of processing timelines and approval patterns would further support assessment of whether expanded hardship eligibility translates into meaningful access rather than procedural delay.

Network Adequacy Standards (§ 155.1050)

Network adequacy remains foundational to meaningful coverage and is essential to ensuring that patients can obtain medically necessary care from qualified providers.[28]

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[26] HealthCare.gov, “Send Documents to Confirm a Special Enrollment Period,” *HealthCare.gov*, accessed March 3, 2026, https://www.healthcare.gov/coverage-outside-open-enrollment/confirm-special-enrollment-period/.

[27] Sabrina Corlette, Jason Levitis, and Tara Straw, *Proposed Marketplace and Insurance Changes in the 2027 Notice of Benefit & Payment Parameters: Implications for States* (Washington, DC: State Health and Value Strategies, February 2026), https://shvs.org/wp-content/uploads/2026/02/Proposed-Marketplace-and-Insurance-Changes-in-the-2027-Notice-of-Benefit-Payment-Parameters_-Implications-for-States_2.13.26.pdf.

The NHC supports rigorous time-and-distance standards, strong provider directory accuracy requirements, and Exchange oversight mechanisms that promote timely access to primary, specialty, and subspecialty care. Network standards are most effective when they operate not only as certification criteria but also as enforceable protections aligned with the lived experience of enrollees seeking care.

If amendments to network adequacy oversight or certification processes are finalized, careful evaluation of impacts on individuals with complex and rare conditions would be beneficial. These individuals often rely on subspecialty providers, tertiary referral centers, and condition-specific expertise. Telehealth services may appropriately supplement access in certain circumstances but may not substitute for in-person specialty services where clinical standards require direct examination or multidisciplinary coordination.

Revisions to network adequacy information collection requirements would be most valuable when focused on data elements that meaningfully inform consumer protection and oversight decisions. Alignment between issuer-submitted network data and consumer-facing provider directories may help reduce discrepancies that undermine consumer trust, while minimizing duplicative reporting burdens.

Essential Community Providers (§ 155.1051)

Essential Community Providers (ECPs) play a critical role in serving populations with significant health and socioeconomic needs, including individuals with chronic conditions who rely on community-based and safety-net providers.[29] The NHC recommends careful evaluation of any proposed changes to ECP participation thresholds or certification standards to help preserve access to care in rural and medically underserved communities.

Changes that reduce ECP participation expectations could have downstream implications for access to primary care, specialty services, and wraparound supports delivered through community-based providers. Continued monitoring of ECP participation levels, network composition, and enrollee access patterns following any finalized changes would help identify unintended access consequences.

Marketing, Web-Brokers, and Enrollment Assistance (§§ 155.220, 155.221)

The NHC supports strong oversight of agents, brokers, web-brokers, and Enhanced Direct Enrollment (EDE) entities, given their central role in connecting consumers to Marketplace coverage. Effective oversight can help prevent unauthorized enrollments,

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[28] Matthew Rae et al., *How Narrow or Broad Are ACA Marketplace Physician Networks?*, KFF, August 26, 2024, https://www.kff.org/private-insurance/how-narrow-or-broad-are-aca-marketplace-physician-networks/.

[29] Rose C. Chu et al., *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces* (Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, December 28, 2021), https://aspe.hhs.gov/reports/standardized-plans-health-insurance-marketplaces.

reduce the risk of consumer confusion, and mitigate plan selection errors that may arise from information asymmetry, complex benefit design, or enrollment channel incentives.

CMS' proposal to require the use of an HHS-approved consumer consent form may promote greater consistency and enforceability if implemented carefully. Standardization can reduce ambiguity in documentation and support accountability where gaps have been identified. To minimize potential enrollment barriers, the NHC encourages development of consent forms that are written in plain language, available in multiple languages, compliant with disability access standards, and operational across electronic and telephonic enrollment channels without delaying coverage effective dates. Clarification of how consent requirements interact with authorized representative designations and documentation retention standards would further support consistent implementation.

The NHC supports continued efforts to address marketing practices that create a risk of consumer misunderstanding. Marketing communications that clearly disclose plan limitations, cost-sharing structures, network constraints, and eligibility implications may improve consumer clarity regarding plan features and coverage conditions. Oversight mechanisms that prioritize documented patterns of consumer harm and focus on material compliance requirements, rather than isolated technical deficiencies, may strengthen accountability while preserving efficient enrollment workflows.

Although the proposed rule does not introduce new regulatory provisions addressing accumulator adjustment programs (AAPs), the NHC continues to hear concerns from patient organizations regarding the potential effects of these practices on patient out-of-pocket affordability.[30,31,32] When manufacturer cost-sharing assistance does not count toward an enrollee's deductible or annual limitation on cost sharing, individuals managing chronic or complex conditions may experience higher-than-anticipated financial exposure during the plan year.[33,34] Greater transparency regarding whether and how these practices are incorporated into plan design would support more informed

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[30] David Sheinson, Aashna Patel, and William Wong, "Patient Liability and Treatment Adherence/Persistence Associated with State Bans on Copay Accumulator Programs," paper presented at the AcademyHealth 2023 Annual Research Meeting, Seattle, WA, June 24–27, 2023, https://academyhealth.confex.com/academyhealth/2023arm/meetingapp.cgi/Paper/57828.

[31] Matthew Ingham et al., "Assessment of Racial and Ethnic Inequities in Copay Card Utilization and Enrollment in Copay Adjustment Programs," *Journal of Managed Care & Specialty Pharmacy* 29, no. 9 (September 2023): 1084–1092.

[32] Michelle Long, Meghan Salaga, and Kaye Pestaina, "Copay Adjustment Programs: What Are They and What Do They Mean for Consumers?" KFF, October 24, 2024, https://www.kff.org/health-costs/copay-adjustment-programs-what-are-they-and-what-do-they-mean-for-consumers/.

[33] David Choi et al., "A Primer on Copay Accumulators, Copay Maximizers, and Alternative Funding Programs," *Journal of Managed Care & Specialty Pharmacy* 30, no. 8 (August 2024): 883–896, https://doi.org/10.18553/jmcp.2024.30.8.883.

[34] Kimberly Westrich et al., "Copay Accumulator and Maximizer Programs: Stakes Rise for Patients as Federal Rulemaking Lags," *Health Affairs Forefront*, March 18, 2025, https://doi.org/10.1377/forefront.20250313.848247.

consumer decision-making during plan selection. [1] The NHC encourages CMS to continue monitoring the prevalence and patient impact of these practices and to evaluate whether additional transparency or consumer protection measures may be warranted to ensure that Marketplace coverage remains predictable and affordable for individuals with ongoing health care needs.

Where related information collection requirements are revised, tailoring reporting to data elements that meaningfully support oversight objectives may help avoid unnecessary administrative friction for legitimate enrollment activities. For changes associated with the State Exchange Enhanced Direct Enrollment option, clear scoping and operational feasibility will remain important to maintain enrollment efficiency and continuity of care.

General Program Integrity and Oversight (§ 155.1200; §§ 155.1600–155.1650)

The NHC supports reasonable and data-driven oversight mechanisms, including improper payment measurement programs and related reporting requirements. Accurate measurement of eligibility determinations and payment accuracy contributes to long-term Marketplace stability and public confidence. Oversight structures are most effective when implemented in a manner that avoids discouraging enrollment among eligible individuals or introducing unnecessary administrative friction into Exchange operations.

Where enhanced reporting, sampling, or documentation standards are proposed under the State Exchange Improper Payment Measurement (SEIPM) program or other oversight authorities, implementation timelines that allow Exchanges and issuers adequate time to modify systems and align workflows may help prevent downstream disruption. Abrupt or poorly sequenced implementation may otherwise affect eligibility determinations or renewal processing.

Calibration of sampling methodologies and documentation workflows to remain proportionate to identified risk areas may further strengthen program integrity while minimizing avoidable coverage disruption. Documentation requests issued near renewal deadlines or coverage effective dates may create uncertainty for consumers and assisters, particularly if duplicative of previously submitted materials. Oversight approaches that reinforce payment accuracy while minimizing administrative churn would best balance integrity objectives with coverage stability.

Discontinuation of Standardized Plan Options and Non-Standardized Plan Limits (§§ 155.20, 156.201, 156.265, 156.202)

The proposal to discontinue standardized plan options and remove limits on the number of non-standardized plans per issuer represents a significant policy shift affecting QHP certification, Exchange display, and consumer decision-making.[35]

[35] Lambrew and Young, “Lessons from ACA.”

Standardized plan designs have historically promoted comparability across issuers, predictable cost-sharing structures, and greater transparency in plan selection.[36] For individuals managing chronic or complex conditions, predictable copayment structures and consistent deductible designs may materially influence access to medications, specialist visits, and ongoing treatment.[37] Eliminating standardized options may increase variation in benefit design, making plan comparisons more difficult and increasing the risk of unexpected out-of-pocket exposure.[38]

Removal of limits on non-standardized plan offerings may also increase plan proliferation within metal levels.[39] While expanded flexibility may support issuer participation and benefit innovation, greater variation in plan designs may increase complexity during plan selection, particularly for individuals with limited access to enrollment assistance. A large number of near-similar plan options can increase cognitive burden and make meaningful comparison more difficult, increasing the likelihood that consumers select coverage that does not align with anticipated health care needs.[40]

If these proposals are finalized, monitoring of consumer experience indicators—such as plan switching patterns, complaint trends related to cost-sharing confusion, and out-of-pocket spending patterns across metal tiers—may help assess impacts.[41] Strengthening Exchange plan comparison tools to maintain clear, consumer-friendly display formats to facilitate clear comparison of deductibles, copayments, and coinsurance structures would further support informed decision-making. Ensuring that any related modifications to reporting or certification information collection requirements preserve consumer-facing transparency may mitigate confusion associated with increased benefit design variation.

Health Insurance Issuer Standards Under the ACA, Including Standards Related to Exchanges (Part 156)

FFE and SBE-FP User Fee Rates for the 2027 Benefit Year (§ 156.50)

CMS proposes to maintain the Federally-facilitated Exchange (FFE) user fee rate at 2.5 percent of total monthly premiums and the State-based Exchange on the Federal platform (SBE-FP) user fee rate at 2.0 percent for the 2027 benefit year. CMS explains that these rates reflect enrollment projections, operational costs, and anticipated state transitions among Exchange models. User fee rates are embedded in issuer premiums

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[36] Chu et al., *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces*.

[37] Pollitz, Lo, and Wallace, “Standardized Plans in the Health Care Marketplace.”

[38] Feher and Menashe, “Reducing Choice Errors among ACA Marketplace Enrollees.”

[39] Lambrew and Young, “Lessons from ACA.”

[40] Faugno et al., “Pick a Plan and Roll the Dice.”

[41] Lambrew and Young, “Lessons from ACA.”

and therefore affect consumer affordability. In a coverage environment characterized by premium sensitivity and income volatility, even incremental administrative cost adjustments warrant careful consideration. Transparency regarding the operational functions supported by user fee collections, and the assumptions underlying rate calculations, will assist stakeholders in understanding how these assessments relate to Marketplace stability and consumer protection functions, particularly for individuals living with chronic and complex health conditions who are more likely to maintain continuous coverage and are therefore more exposed to premium pressure.

As CMS finalizes user fee rates for 2027, the NHC encourages continued transparency regarding the assumptions that drive the proposed rates and how CMS evaluates the relationship between user fee collections and the operational costs of Exchange functions. The NHC also encourages CMS to continue prioritizing operational efficiencies that limit unnecessary premium pressure while preserving strong consumer protection and program integrity functions. Where CMS anticipates meaningful changes to enrollment or operational needs between the proposed and final rule, timely explanation of updated assumptions would support stakeholder understanding and reduce uncertainty for issuers and Exchanges planning for the 2027 benefit year.

Permitting Plan-Level Adjustments for Multi-Year Catastrophic Plans (§ 156.80(d)(2)(ii))

CMS proposes to amend § 156.80(d)(2)(ii) to permit issuers offering multi-year catastrophic plans to make plan-level adjustments to the index rate to reflect the length of the plan term and related benefit design characteristics. CMS frames this proposal as a refinement to premium rate development standards intended to support actuarially sound pricing for plan designs that may vary from traditional single-year catastrophic products.

Plan-level index-rate adjustments associated with multi-year catastrophic terms may introduce additional complexity into premium comparability and consumer understanding. Catastrophic plans already involve high deductibles and substantial cost-sharing exposure, and differences in pricing assumptions tied to plan duration or benefit design may not be readily apparent in consumer-facing materials. Without clear explanation of the basis for these adjustments, consumers and enrollment assisters may have difficulty determining whether premium differences reflect plan term structure or other underlying design features.

If CMS finalizes the ability to make plan-level adjustments for multi-year catastrophic plans, the NHC recommends that CMS reinforce robust transparency expectations in issuer submissions and review processes, including clear documentation of the assumptions and rationale supporting any plan-level adjustment associated with term length. The NHC also encourages CMS to monitor whether these pricing flexibilities, in combination with multi-year catastrophic plan design, create incentives that contribute to risk pool effects, including enrollment patterns that may disproportionately concentrate higher-need enrollees outside of catastrophic products and increase premiums for consumers who require more comprehensive coverage.

State Selection of Essential Health Benefits Benchmark Plans (§ 156.111)

CMS states that it is pausing review of state applications to update essential health benefits (EHB)-benchmark plans while conducting a comprehensive review of section 1302 of the ACA and considering potential future rulemaking related to § 156.111 and other EHB regulations. CMS frames the pause as an interim administrative step while it evaluates the statutory framework and related regulatory policy.

The NHC recognizes CMS' interest in ensuring that EHB policy remains aligned with statutory requirements and administratively coherent. The EHB framework is foundational to comprehensive coverage, including for individuals managing chronic disease, disability, and other ongoing health needs who rely on medically necessary benefits that can vary meaningfully depending on benchmark design and coverage norms.

The NHC also encourages CMS to continue evaluating how EHB classifications interact with the ACA's annual limitation on cost sharing. While EHB requirements formally apply to individual and small group coverage, EHB designations are also used to determine which services are included in the calculation of the statutory out-of-pocket maximum across many non-grandfathered plans.[42] Providing additional clarity regarding how prescription drug coverage is treated for these purposes may help support consistent implementation of the ACA's consumer protection framework. Greater transparency around how covered prescription drugs are classified for purposes of the annual limitation on cost sharing would help ensure that patients managing chronic conditions can better anticipate their potential financial exposure and understand how their plan's cost-sharing protections apply in practice.

At the same time, the benchmark selection and update process has served as a key mechanism for states seeking to modernize benefits and respond to changes in clinical practice, benefit gaps, and evolving population health needs. A pause in review may delay state efforts to strengthen coverage in areas that are particularly relevant for patients, including behavioral health, chronic disease management, and benefit categories where coverage norms have shifted since many benchmark plans were originally established.

The NHC also encourages CMS to carefully evaluate the potential implications of the proposed changes to how state-mandated benefits are treated relative to EHB and federal defrayal requirements. States have historically used benefit mandates to address gaps in coverage and respond to evolving clinical standards, including in areas such as behavioral health services, chronic disease management, and specialized diagnostic testing.[43] Changes in how mandated benefits are classified for defrayal

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[42] Allison Monahan, "The Regulatory Failure to Define Essential Health Benefits," *American Journal of Law & Medicine* 44, no. 4 (2018): 535–537, https://doi.org/10.1177/0098858818821136.

[43] Sara Collins, Justin Giovannelli, and Sabrina Corlette, *Enhancing Essential Health Benefits: States Updating Benchmark Plans to Reflect New Health Needs* (Commonwealth Fund, November 14, 2024),

purposes may influence state decisions regarding whether to adopt or maintain certain coverage requirements.[44,45] As CMS considers implementation of this proposal, continued attention to potential patient access implications will be important to ensure that regulatory changes do not inadvertently discourage coverage expansions that improve access to medically necessary services.

The NHC therefore encourages CMS to provide greater predictability regarding the scope and expected duration of the pause, including the operational implications for states that have initiated stakeholder processes or invested administrative resources in preparing benchmark update applications. Clarity regarding anticipated timelines for future rulemaking would also support more orderly planning by states, issuers, and consumer assistance entities. Predictable benefit policy is important because uncertainty can delay coverage improvements and complicate consumer understanding of required benefits over time.

Provision of EHBs—Routine Non-Pediatric Dental Services (§ 156.115(d))

CMS proposes to reinstate the regulatory prohibition on issuers including routine non-pediatric dental services as an EHB, reversing the policy finalized in the 2025 Payment Notice. CMS frames the proposal as a statutory interpretation issue grounded in section 1302(b) and the structure of the EHB categories, which explicitly include pediatric oral services but do not include routine non-pediatric dental services.

The NHC understands CMS' stated interpretation of the statutory structure and the agency's position that routine adult dental coverage is often offered as a separate benefit rather than embedded within comprehensive medical coverage.[46] The NHC also notes that CMS is seeking to apply a consistent national framework for EHB requirements and to avoid regulatory uncertainty about the permissible scope of benchmark updates.

However, the NHC emphasizes that oral health is closely linked to overall health outcomes and care management. For individuals living with chronic conditions, routine dental care can affect treatment adherence, infection risk, nutrition, and comorbidity control, and can help prevent complications that lead to avoidable downstream medical

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https://www.commonwealthfund.org/publications/issue-briefs/2024/nov/enhancing-essential-health-benefits-states-updating-benchmark-plans.

[44] California Health Benefits Review Program, *Essential Health Benefits and State Defrayal Requirements* (California Health Benefits Review Program, August 2023), https://www.chbrp.org/sites/default/files/2023-08/EHB_Defrayal_FINAL.pdf.

[45] Collins, Giovannelli, and Corlette, *Enhancing Essential Health Benefits*.

[46] Hawazin Elani et al., "Availability of Adult Dental Plans in the Affordable Care Act Marketplaces," *Health Affairs* (2024), https://doi.org/10.1377/hlthaff.2024.00307.

utilization.[47,48,49] Limiting sate flexibility to integrate routine adult dental benefits into comprehensive coverage designs may have practical implications for patient health and affordability, particularly for low-income populations who face significant barriers to dental access and are less likely to purchase separate stand-alone dental coverage.[50]

If CMS finalizes the prohibition, the NHC recommends that CMS clearly articulate viable pathways through which states and issuers may continue to support adult dental access outside the EHB framework without creating coverage fragmentation or administrative complexity that deters enrollment. The NHC also encourages CMS to evaluate and describe the likely consumer impacts of the policy, including whether it increases the likelihood that consumers forgo dental coverage entirely and whether coverage separations create barriers for patients who require coordinated medical and dental care.

Publication of the 2027 Premium Adjustment Percentage and Related Parameters in Guidance (§ 156.130(e))

CMS indicates that, because it is not proposing methodological changes for the 2027 benefit year, it has published the premium adjustment percentage and related parameters in guidance rather than through notice-and-comment rulemaking for this year. CMS also solicits comment on whether the methodology for estimating the premium adjustment percentage should better reflect per capita claims cost growth in the individual market, particularly in light of the downstream effects these parameters have on cost-sharing limits and plan design feasibility.

The premium adjustment percentage and related parameters, including the maximum annual limitation on cost sharing and associated affordability thresholds, are central components of the Affordable Care Act's financial protection framework. These parameters materially influence plan design, actuarial value calculations, and the degree of financial risk borne by consumers.

Given the role these parameters play in the proposed rule's broader discussion of actuarial constraints and cost-sharing dynamics, maintaining a high level of transparency regarding the inputs, assumptions, and methodological rationale used to calculate the premium adjustment percentage and related parameters will be important,

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[47] Molly Linabarger, Monique Brown, and Nita Patel, "A Pilot Study of Integration of Medical and Dental Care in 6 States," *Preventing Chronic Disease* 18 (2021): 210027, https://doi.org/10.5888/pcd18.210027.

[48] Yoonsang Huh et al., "Association of Dental Diseases and Oral Hygiene Care with Heart Failure Development among Patients with Type 2 Diabetes," *Journal of the American Heart Association* 12 (2023), https://doi.org/10.1161/JAHA.122.029207.

[49] Pinelopi Petropoulou et al., "Oral Health Education in Patients with Diabetes: A Systematic Review," *Healthcare* 12, no. 9 (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC11083353/.

[50] Sara Reyna et al., *Recommendations for Improving Oral Health Care Access, Quality, and Equity* (Baltimore: Centers for Medicare & Medicaid Services, 2024), https://www.medicaid.gov/medicaid/benefits/downloads/ohi-exp-workgroup-rpt.pdf.

even when those values are issued through guidance. To the extent CMS considers refinements to the methodology in future years, evaluation through the lens of financial protection and affordability will also be important, including consideration of potential interactions with actuarial value calculations, premium tax credit dynamics, and the long-term integrity of cost-sharing limits as meaningful consumer safeguards.

Multi-Year Terms for Catastrophic Plans (§§ 156.130(c) and 156.155(a)(6))

CMS proposes to codify standards permitting catastrophic plans to have terms of up to ten consecutive years and to allow certain value-based insurance design features in multi-year catastrophic plans. CMS describes potential benefits such as reduced churn and longer-term issuer incentives to invest in preventive care and enrollee engagement, while also seeking comment on how multi-year catastrophic coverage interacts with other ACA and Marketplace policies.

The NHC appreciates CMS' stated objective of improving continuity in a market where consumers frequently experience transitions. Continuity can be valuable for patients if it supports sustained access to clinicians, stable medication management, and reduced administrative disruption that can interfere with ongoing treatment.

However, multi-year catastrophic structures also raise distinct concerns given the frequency of changes in income, employment, eligibility for other coverage, and health status among individual market enrollees.[51,52] Multi-year commitment features that are not clearly understood, or that are operationally difficult to exit in practice, could disadvantage consumers whose health needs evolve and who require more comprehensive coverage. These risks are particularly relevant for individuals who develop chronic conditions or experience new diagnoses during the term of a multi-year catastrophic product.

Accordingly, the NHC encourages CMS to ensure that any multi-year catastrophic framework preserves meaningful consumer flexibility and is accompanied by clear, plain-language disclosures describing the practical implications of multi-year enrollment, including the consumer's ability to change plans, transition between metal levels, or move to other coverage when circumstances change. The NHC also encourages CMS to resolve and clearly describe the operational interactions CMS identifies, including with risk adjustment, medical loss ratio requirements, guaranteed availability, and tax-related policies, before multi-year catastrophic products scale in a manner that could materially affect enrollment patterns and risk pool composition.

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[51] Jacqueline Pesa et al., "Real-World Analysis of Insurance Churn among Young Adults with Schizophrenia Using the Colorado All-Payer Claims Database," *Journal of Managed Care & Specialty Pharmacy* 28, no. 1 (2022): 26–34, https://doi.org/10.18553/jmcp.2022.28.1.26.

[52] Musumeci et al., *Reducing Medicaid Churn.*

Cost-Sharing for Bronze and Catastrophic Plans (§§ 156.136 and 156.155)

CMS describes what it characterizes as an increasingly binding interaction among the actuarial value (AV) calculation, the evolving standard population, growth in EHB costs, and annual increases in the maximum annual limitation on cost sharing derived from the premium adjustment percentage. CMS asserts that these combined dynamics may, over time, constrain issuers' ability to design bronze and catastrophic plans that both comply with statutory cost-sharing limits and fit within the applicable AV parameters, and CMS solicits comment on potential regulatory approaches to preserve the continued availability of these plan types.

To address these constraints, CMS proposes to permit certain individual market bronze plans to exceed the maximum annual limitation on cost sharing in $50 increments for purposes of meeting the bronze de minimis range, provided that the issuer offers at least one bronze plan in the same service area that complies with the statutory maximum. CMS also proposes to modify catastrophic plan requirements such that catastrophic plans would provide no benefits until an enrollee reaches an amount equal to 130 percent of the maximum annual limitation on cost sharing.

The NHC appreciates CMS' transparency in describing the underlying actuarial problem and its effort to avoid a scenario in which core product categories become nonviable under the current parameter structure. Preserving a workable bronze tier is relevant to consumer choice architecture and to overall market stability, including for individuals who prioritize lower premiums and for consumers who use the bronze tier as an entry point into coverage. Likewise, catastrophic coverage has historically functioned as a limited-premium option for consumers who can tolerate higher cost exposure in exchange for lower monthly payments.

At the same time, the maximum annual limitation on cost sharing is among the ACA's most important financial protection provisions. Allowing any plan to exceed that limit, even in defined increments and even with a requirement to offer at least one compliant alternative, represents a significant policy departure that raises consumer protection concerns. In practice, plan selection is often shaped by premium salience and choice architecture, including default sorting, display design, and the limits of consumers' ability to translate cost-sharing features into expected out-of-pocket exposure.[53,54,55] As a result, the existence of one compliant bronze plan in a service area may not, by itself, ensure adequate protection from increased out-of-pocket liability if alternative designs are displayed or perceived as more financially attractive based on premium.

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[53] George Loewenstein et al., "Consumers' Misunderstanding of Health Insurance," *Journal of Health Economics* 32, no. 5 (September 2013): 850–862, https://doi.org/10.1016/j.jhealeco.2013.04.004.

[54] Annabel Wang et al., "Poor Consumer Comprehension and Plan Selection Inconsistencies Under the 2016 HealthCare.gov Choice Architecture," *MDM Policy & Practice* 2, no. 1 (June 28, 2017): 2381468317716441, https://doi.org/10.1177/2381468317716441.

[55] Jason Abaluck and Jonathan Gruber, "Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program," *American Economic Review* 101, no. 4 (June 2011): 1180–1210, https://doi.org/10.1257/aer.101.4.1180.

The NHC is similarly concerned about the proposed catastrophic plan approach requiring no benefits until 130 percent of the maximum annual limitation on cost sharing is reached. Catastrophic plans already entail substantial exposure through high deductibles and limited pre-deductible coverage. Increasing the point at which benefits begin could further reduce the practical value of catastrophic coverage for consumers who experience high but not fully catastrophic utilization, including individuals with episodic health needs, new diagnoses, or conditions requiring significant but intermittent specialty care. The proposal may therefore increase the risk that enrollees defer or discontinue needed services due to cost, which can result in worse health outcomes and higher downstream spending.

If CMS finalizes either proposal, the NHC recommends that CMS adopt consumer-facing safeguards designed to ensure that increased cost-sharing exposure is transparent and does not functionally undermine financial protection for individuals with chronic or serious health needs. At a minimum, effective implementation would require clear and prominent disclosures in Exchange display tools and summaries of benefits and coverage indicating when a bronze plan exceeds the maximum annual limitation on cost sharing and how catastrophic coverage operates relative to the 130 percent threshold. The NHC recommends that CMS also monitor enrollment distribution across compliant and noncompliant bronze offerings, changes in out-of-pocket spending patterns, grievances and appeals related to cost-sharing misunderstandings, and any indications of risk pool effects associated with higher cost-sharing designs.

CMS also solicits comment on whether adjustments to the methodology for estimating the premium adjustment percentage could better align annual increases in the maximum annual limitation on cost sharing with per capita claims cost growth in the individual market. The NHC supports CMS' examination of whether the current parameter methodology is producing compounding effects that distort plan design feasibility over time. To the extent CMS concludes that a methodology update is necessary, the NHC encourages CMS to pursue an approach that preserves the integrity of statutory affordability protections and reduces the need for workarounds that permit plans to exceed established consumer protection ceilings.

Discontinuation of Standardized Plan Options (§§ 155.20; 156.201; 156.265; related provisions)

CMS proposes to discontinue the standardized plan option framework beginning in plan year 2027. CMS frames this proposal as a means of increasing issuer flexibility in plan design and reducing constraints that may limit product variation within metal levels. Standardized plan designs have historically served as an important consumer protection mechanism within the Exchanges by promoting comparability across issuers, limiting variation in cost-sharing structures, and reducing complexity during plan selection. For individuals managing chronic or complex health conditions, predictable copayment structures, consistent application of deductibles, and more uniform tiering conventions can materially influence treatment adherence, medication access, and the ability to anticipate out-of-pocket exposure over the course of the plan year.

The NHC acknowledges that CMS is seeking to promote issuer flexibility and, potentially, greater product innovation. At the same time, eliminating standardized plan options may increase heterogeneity in benefit design in ways that make it more difficult for consumers to meaningfully compare plans.[56] Differences in deductible structure, pre-deductible coverage, specialty drug tiering, and coinsurance rates may be difficult for consumers to evaluate when reviewing plan materials, particularly under time constraints or when enrollment assistance is limited.[57]

If CMS finalizes the discontinuation of standardized plan options, the NHC encourages CMS to strengthen consumer-facing transparency and plan comparison functionality to preserve comparability across core cost-sharing elements. Decision-support tools should allow consumers to readily evaluate differences in deductibles, pre-deductible coverage, copayment versus coinsurance structures for common services, specialty drug tiering, and maximum out-of-pocket exposure. CMS could also assess post-implementation consumer experience indicators, including plan switching patterns, complaint trends related to cost-sharing misunderstandings, and observed out-of-pocket spending patterns across plan types and metal levels, to evaluate whether increased benefit design variation affects consumers' ability to select plans that align with expected health care needs.

Finally, the NHC encourages CMS to consider whether maintaining at least one standardized option within each metal tier could preserve a baseline comparability benchmark while still allowing broader issuer flexibility. A clearly identifiable reference design within each metal level may provide consumers with a practical anchor for plan comparison without fully constraining issuer product design.

Non-Standardized Plan Option Limits and Exceptions (§ 156.202)

CMS also proposes to remove limits on the number of non-standardized plans that an issuer may offer within a service area and metal level. CMS frames this proposal as expanding issuer flexibility and reducing constraints that may limit issuer participation or tailored benefit design strategies. The NHC notes that issuers may seek to differentiate products to meet varied consumer preferences and that flexibility can, in some circumstances, support broader market participation.

At the same time, removing limits on non-standardized plan offerings may substantially increase the number of plan variations presented to consumers within a given metal level and service area. As discussed above with respect to standardized plan discontinuation, increased variation across plan designs can make meaningful comparison more difficult for consumers evaluating Exchange coverage options. When consumers are presented with a large number of similar plans that differ primarily in subtle cost-sharing features, plan selection may increasingly rely on simplified heuristics

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[56] Faugno et al., "Pick a Plan and Roll the Dice."

[57] Rachel Fehr, Cynthia Cox, and Larry Levitt, *Insurer Participation on ACA Marketplaces, 2014–2019*, Issue Brief (Henry J. Kaiser Family Foundation, November 2018), https://collections.nlm.nih.gov/catalog/nlm:nlmuid-101740400-pdf.

rather than detailed evaluation of deductible structures, cost-sharing for frequently used services, or specialty drug tiering.[58] These dynamics may be particularly consequential for individuals with predictable or ongoing health care needs, for whom misalignment between anticipated utilization and plan benefit design can result in higher-than-expected out-of-pocket costs or disruption of care if coverage does not align with treatment patterns.

If CMS finalizes the removal of non-standardized plan limits, the NHC encourages CMS to ensure that QHP certification standards and Exchange display environments support meaningful differentiation and consumer comprehension. Consumers should be able to readily compare plans based on features that drive real-world affordability and access, including deductible design, cost-sharing for high-frequency services, specialty drug tiering, and network characteristics. CMS could also assess whether increased plan proliferation is associated with indicators of consumer confusion or dissatisfaction, including complaint patterns, unexpected out-of-pocket spending, or coverage dissatisfaction among enrollees with predictable utilization needs.

Finally, issuer submission requirements and certification review processes associated with this proposal should remain focused on transparency and comparability while maintaining administratively efficient review processes. Alignment between regulatory submission standards and consumer-facing plan display formats may help ensure that the information used for regulatory review is consistent with the information consumers encounter during plan selection.

Network Adequacy Reviews (§ 156.230)

The NHC supports rigorous network adequacy standards as a prerequisite for meaningful coverage. For individuals living with chronic and rare conditions, network adequacy depends not only on the presence of general provider categories, but also on reliable access to appropriate specialists, subspecialists, tertiary care providers, and condition-specific expertise. In practice, factors such as network breadth, provider panel availability, and appointment wait times can influence whether enrollees are able to obtain timely care even when networks satisfy regulatory standards.

To the extent CMS proposes changes affecting network adequacy review processes and associated standards under § 156.230, the NHC encourages CMS to prioritize oversight approaches that reflect real-world access. Aligning issuer-submitted network information with consumer-facing directories remains important to reduce discrepancies that undermine consumer confidence and may contribute to mid-year care disruption. The NHC also encourages CMS to consider whether additional indicators—such as appointment wait times, provider panel capacity, or patterns of out-of-network utilization—could provide additional insight into whether certified networks support timely access for enrollees with ongoing medical needs.

If CMS finalizes modifications to network adequacy review processes, monitoring consumer experience metrics—including complaint trends and continuity-of-care

[58] Fehr, Cox, and Levitt, *Insurer Participation on ACA Marketplaces*

disruptions associated with network changes—may help CMS evaluate how network adequacy standards operate in practice for enrollees seeking care.

Non-Network Plan Certification and Patient Access Protections (§ 156.236)

The proposed rule would allow plans that do not maintain a traditional provider network to qualify for certification as QHPs, provided they meet specified requirements regarding payment terms and access to providers willing to accept the plan's benefit amount as payment in full. While the NHC appreciates CMS's effort to introduce flexibility into plan design, the NHC is concerned that the certification of non-network plans could create new risks for patients and caregivers if appropriate safeguards are not established.

For patients with chronic, complex, or rare conditions, meaningful coverage depends not simply on theoretical access to providers but on the practical ability to obtain care from clinicians willing to treat them under the plan's payment terms. In the absence of a defined provider network, patients may face significant uncertainty regarding whether clinicians will accept the plan's payment as payment in full. This uncertainty may be particularly acute for individuals requiring specialty care, tertiary care centers, or highly specialized treatment providers.

The NHC therefore encourages CMS to ensure that any certification pathway for non-network plans includes strong patient protections. At a minimum, the NHC urges CMS to require clear consumer disclosures regarding how enrollees can identify providers willing to accept the plan's payment terms, establish monitoring mechanisms to ensure adequate provider participation, and provide robust complaint and grievance processes for enrollees who experience difficulty accessing care. The NHC also urges CMS to closely monitor whether non-network plan structures create unintended financial exposure for patients seeking medically necessary services. The NHC further encourages CMS to specify a core set of reporting elements—including but not limited to provider acceptance rates, out-of-network utilization, complaint categories, and resolution timelines—and to publish these data in an accessible format to support oversight and consumer understanding.

Quality Improvement Strategy Information (§ 156.1130)

CMS proposes changes to QIS information requirements beginning with plan year 2027, including allowing issuers to address any two of the five statutory topic areas rather than requiring specific topics. Flexibility in topic selection may allow issuers to tailor improvement strategies to local enrollee populations. However, the value of flexibility depends on whether QIS submissions continue to demonstrate measurable impacts on enrollee outcomes, care coordination, and patient experience rather than functioning primarily as process-oriented reporting. The NHC recognizes the potential value of flexibility if it allows issuers to select improvement strategies that are responsive to enrollee needs and local market conditions, provided that QIS submissions continue to demonstrate measurable improvements in enrollee outcomes, care coordination, and patient experience rather than primarily documenting process-oriented activities.

For individuals managing chronic and complex conditions, the most meaningful quality improvement initiatives are those that measurably improve care coordination,

medication adherence, transitions between care settings, behavioral health integration, and patient experience, including timely access to specialty care. The NHC encourages CMS to maintain expectations that QIS submissions demonstrate measurable impact and clear accountability, with sufficient specificity to permit meaningful review and to distinguish substantive strategies from process-oriented activities that impose administrative burden without improving care.

The NHC also encourages CMS to consider opportunities for alignment across quality-related reporting frameworks where feasible, to reduce duplicative administrative requirements while preserving the QIS program's distinct purpose as a Marketplace consumer protection and quality improvement mechanism. This could include clarifying when existing issuer quality reporting can be referenced in QIS submissions, while preserving the QIS requirement to describe Marketplace-relevant interventions and measurable results for Exchange enrollees.

Issuer Use of Premium Revenue: Reporting and Rebate Requirements (Part 158)

Comment Solicitation on Potential Adjustment to the MLR for a State's Individual Market (Subpart C)

CMS solicits comment on whether and how the Secretary may adjust the Federal medical loss ratio (MLR) standard applicable to a State's individual market under section 2718(b) of the Public Health Service Act and 45 CFR part 158, subpart C. CMS references the statutory authority permitting adjustment of the 80 percent MLR standard where application of that standard may destabilize the individual market in a state and seeks input on potential modifications to the existing framework, including whether adjustments might be initiated absent a state request and whether related documentation and duration requirements should be revised.

The MLR framework remains one of the ACA's central consumer protections. By establishing a minimum percentage of premium revenue that must be devoted to clinical services and quality improvement activities, the 80 percent standard operates as both a floor for consumer value and a stabilizing mechanism that encourages administrative efficiency. The MLR rebate requirement also functions as a back-end safeguard that returns premium dollars to consumers when plan spending falls below the statutory threshold.

The NHC recognizes that CMS is examining whether targeted adjustments to the MLR standard could, in limited circumstances, promote market stability, including in states experiencing issuer exits or structural instability. Historically, this authority has been exercised through a state-initiated request process, reflecting a framework in which states present actuarial and market evidence to support a temporary modification.

At the same time, lowering the MLR standard in the individual market represents a policy change with direct implications for the allocation of premium revenue devoted to clinical services and quality improvement and, correspondingly, the amount available for administrative and other non-claims costs. While it is sometimes asserted that reducing the MLR threshold could allow issuers to price more aggressively or maintain

participation in challenging markets, the relationship between a lower MLR standard and reduced premiums is neither automatic nor guaranteed. In certain circumstances, a lower MLR threshold could reduce rebate payments without a clear demonstration of corresponding affordability gains for consumers.

The NHC therefore encourages CMS to treat MLR adjustment authority as a narrowly tailored tool reserved for clearly demonstrated circumstances of market destabilization. Any consideration of federal-initiated adjustments, absent a state request, warrants particular caution. The state-based request process embedded in subpart C reflects a deliberate balance between federal oversight and state-specific market knowledge. States are often best positioned to assess local enrollment patterns, issuer participation trends, reinsurance dynamics, and consumer impacts. If CMS were to contemplate a federal-initiated pathway, preservation of robust consultation with affected states and an opportunity for public comment prior to final determination would be important safeguards to maintain transparency and legitimacy.

CMS also seeks comment on whether MLR adjustments could mitigate incentives for market consolidation. The NHC encourages careful examination of the empirical basis for that assumption. Market consolidation is influenced by multiple structural factors, including provider market concentration, administrative scale, reinsurance programs, premium tax credit dynamics, and enrollment volatility. Adjustments to the MLR standard may have limited capacity to alter these underlying drivers. A clear articulation of the causal theory linking MLR modification to reduced consolidation would be important before pursuing policy changes on that basis.

With respect to potential revisions to subpart C—including extending the duration of state-requested adjustments from three to five reporting years and modifying information submission requirements under §§ 158.320 and 158.321—the NHC supports reasonable burden reduction where it does not compromise analytical rigor. Any extension of adjustment duration would benefit from clearly defined criteria and periodic reassessment to ensure that the underlying destabilization conditions persist and that consumer impacts remain justified. Similarly, streamlined documentation requirements should retain sufficient actuarial and market evidence to support a defensible determination under § 158.330.

CMS also seeks comment on whether CMS should publish the data and analyses underlying a determination that an MLR adjustment is warranted. The NHC supports routine public release of such data and analysis. Because MLR standards affect premiums, rebate payments, and the allocation of premium dollars between patient care and administrative uses, public confidence in any adjustment depends on transparency regarding the evidentiary basis, methodology, and anticipated consumer impact. Clear explanation of the expected effects on premiums, rebates, issuer participation, and market stability would support informed stakeholder engagement and accountability.

Finally, the NHC emphasizes that the MLR framework operates in concert with other ACA mechanisms, including risk adjustment, rate review, premium tax credit calculations, and cost-sharing parameters. Modifications to MLR standards should therefore be evaluated holistically to ensure that interactions across Parts 153, 154,

155, and 156 do not produce unintended consequences that undermine affordability or financial protection in the individual market.

Basic Health Program Payment Methodology

The proposed rule includes revisions to the methodology used to determine federal payments to states operating Basic Health Programs (BHPs). The BHP serves individuals with incomes above Medicaid eligibility levels but below the thresholds for full Marketplace participation in certain states and provides an important coverage option for individuals and families with limited financial resources.

Because federal BHP payments are calculated using factors related to Marketplace subsidies and enrollment characteristics, changes to the payment methodology may have downstream implications for the financing and stability of BHP programs. For patients and caregivers enrolled in BHP coverage, stability in program financing is closely tied to the ability of states to maintain affordable premiums, predictable benefits, and continuity of coverage. Changes in payment methodology may therefore affect state program design, enrollment patterns, and the affordability of coverage for individuals who rely on BHP programs as a primary source of insurance.

In evaluating the proposed revisions, careful consideration of potential effects on state program financing and enrollment patterns would be valuable, particularly in circumstances where methodological changes could materially affect federal payment levels. Where significant changes in funding levels may occur, transition considerations could help reduce the risk of program disruption. Publication of clear analyses describing the projected effects of the revised methodology on BHP payments and enrollment would also support transparency and help states, patients, and caregivers better understand how revisions to the payment methodology may affect coverage affordability and access.

Cross-Cutting Impact on Individuals with Chronic Conditions and Disabilities

Across Parts 150 through 158, CMS proposes a series of policy changes affecting eligibility verification, advance payments of the premium tax credit, Special Enrollment Period documentation, benefit design flexibility, rate transparency, marketing oversight, and program integrity standards. Although each proposal is addressed within a distinct regulatory framework, the NHC encourages CMS to evaluate the cumulative impact of these changes on individuals managing chronic, complex, or disabling health conditions.

Individuals with ongoing medical needs are particularly sensitive to coverage instability, administrative delays, and variability in cost-sharing structures.[59] These effects can be amplified for caregivers who must navigate eligibility rules, plan comparisons, and documentation timelines while simultaneously managing treatment schedules and daily care needs.[60] Modifications to eligibility verification processes, pre-enrollment SEP

[59] Goldman and Gordon, “Coverage Disruptions Across the ACA’s Medicaid/Marketplace Income Cutoff.”

review, standardized plan availability, network adequacy oversight, and reporting requirements may be reasonable when assessed independently. However, when implemented concurrently, these policies may interact in ways that increase enrollment churn, delay coverage activation, or introduce unpredictability in out-of-pocket costs.

The NHC therefore urges CMS to assess these provisions collectively rather than solely on a provision-by-provision basis. For individuals who experience income volatility due to episodic work capacity or disability, rely on specialty or subspecialty providers, depend on predictable copayment structures for high-cost therapies, or require enrollment assistance to navigate Marketplace processes, even modest increases in documentation complexity or plan variability can have outsized effects on access to care.

As CMS finalizes policy changes in this rulemaking, Marketplace reforms need to preserve comprehensive coverage, maintain meaningful access to specialty providers and medically necessary therapies, promote predictable and transparent cost sharing, and minimize avoidable administrative barriers to enrollment and renewal. Ongoing monitoring of coverage continuity metrics, reenrollment rates, consumer complaint trends, and patterns of coverage disruption would help ensure that integrity and flexibility objectives do not inadvertently undermine patient access or affordability for individuals with chronic conditions.

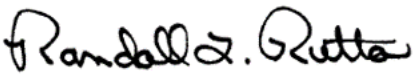
Conclusion

The NHC appreciates CMS' ongoing efforts to refine Marketplace operations and strengthen program integrity. As the Agency finalizes the 2027 NBPP, we encourage careful consideration of how the proposed changes will affect coverage access, financial protection, and health outcomes for the millions of Americans who rely on the individual market.

The NHC stands ready to continue working with CMS to ensure that Marketplace coverage remains stable, affordable, and patient-centered. Please do not hesitate to contact Kimberly Beer, Senior Vice President, Policy & External Affairs at kbeer@nhcouncil.org or Shion Chang, Assistant Vice President, Policy & Regulatory Affairs at schang@nhcouncil.org, if you or your staff would like to discuss these comments in greater detail.

We appreciate the opportunity to provide these comments and look forward to ongoing collaboration.

Sincerely,



Randall L. Rutta
Chief Executive Officer

[60] AARP and National Alliance for Caregiving, *Caregiving in the United States 2025*.